

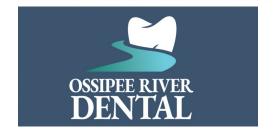
Signature of Guarantor of payment/responsible party

PERSONAL INFORMATION

Name	Birth Date Social Security #
	Sex: ☐ Female ☐ Male
Mailing Address	
Physical Address	
Occupation: Employer Nan	ne & Address
Phones: Home Cell e-mail Phone email email Phone email	Work
Marital Status: □ Single □ Married □ Partner	□ Divorced □ Separated □ Widowed □ Child
Spouse name:	
Parent information (if patient is a child):	
	Daytime phone
	lailing Address
Is any other member of your family a patient in our practice?	
If new to Sacopee Valley Family Dental, who may we thank for recommend	ding our office to you?
PRIMARY INSURANCE INFORMATION	
	nip to Patient □ Patient □ Spouse □ Child □ Other:
Employer Name & Address	
Employer Address 2	
Insurance Company Name & Address	
Insurance Company Address 2	
	Date of Birth
SECONDARY INSURANCE INFORMATION	
Name of Insured Relationsh	nip to Patient Patient Spouse Child Other:
Employer Name & Address	
Employer Address 2	
Insurance Company Name & Address	
Insurance Company Address 2	
Carrier ID Soc. Sec. #	
CONSENT FOR SERVICES As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or	tions to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
Signature of patient, parent or guardian	Date Relationship to Patient

Date

Relationship to Patient



FINANCIAL POLICY

We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is necessary in order for us to provide treatment.

PATIENTS WITH DENTAL INSURANCE

As a courtesy to our patients, we prepare and process all insurance forms. However, having insurance does not release the patient from responsibility. Our expectations of you as the owner of the policy are as follows:

- 1. Estimated patient portions must be paid at the time of service. This may include co-payments, deductibles, co-insurance and/ or non-covered procedures.
- 2. You are responsible for educating yourself about the details of your policy which includes deductibles, yearly maximums, and policy exclusions.
- 3. If the insurance company does not pay our office within 60 days, if is your responsibility to pay using one of the payment methods listed below. The insurance policy belongs to you and we have no leverage to obtain payment.

A rebilling charge of 1.5% per month (annual percentage rate of 18%) will be assessed on any unpaid balance over 90 (ninety) days regardless of insurance estimates. Insurance estimates are based on limited information provided to our office by your insurance company and is not a guarantee of coverage or payment.

PATIENTS WITHOUT DENTAL INSURANCE

If you have no insurance coverage, full payment is due at the time of service with one of the payment options listed below.

PAYMENT OPTIONS

For your convenience, you may choose any of the following methods of payment:

- Cash
- Personal Check, postdated if necessary (returned check fee will be charged at \$35 per check)
- Visa, MasterCard, Discover, American Express Credit or Debit
- Extended Payment Plan with our Financing Partner, Care Credit. Short-term plans may be available with no interest. Credit
 approval must be received prior to treatment.
- · Payment Plans may be available at the office's discretion. Arrangements must be made prior to treatment.

SHORT NOTICE CANCELLATIONS & MISSED APPOINTMENTS

Please make every effort to keep your scheduled appointments. If you must cancel or reschedule, kindly notify us at least 24 hours in advance. There is a \$35 charge for all appointments that are cancelled or missed without a 24 hour notice.

MINOR PATIENTS

The parent, guardian, or adult accompanying and signing all forms for a minor will be responsible for full payment. Parents or guardians must be present to authorize all dental treatment for minors.

Release of Information and Insurance Payment Authorizations

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I hereby authorize and direct payment of dental benefits otherwise payable to me, directly to the dentists at Sacopee Valley Family Dentistry.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges incurred by my dependent(s), or myself, whether or not covered by insurance. I agree to pay Sacopee Valley Family Dentistry for professional services rendered to me or my dependent(s) at the time of service. If my insurance pays less than estimated, I agree to pay any remaining balance within 30 (thirty) days of billing. I expressly agree to pay all costs of collection agency fees assessed at 40% of the total amount due, and all court costs and attorney fees, if these terms are not met.

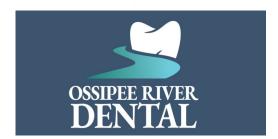
Signature:		Date:	
	(Patient, legal guardian or authorized agent of patient)		



HEALTH HISTORY & COMMUNICATION

*Updated Annually

Patient Legal Name:				Date of Birth:	
Mailing Address:		MI	L	ast	
	City y if patient is a minor)			State	Zip
CELL ()	Okay to le	ave message? ☐ Yes ave message? ☐ Yes	□ No **Exte	ended Message? ☐ Yes ☐ NO ☐ ended Message? ☐ Yes ☐ NO ☐ ended Message? ☐ Yes ☐ NO ☐	**extendend messages may conatin clinical and/or prescription info
	Cell: _				
Do you have Dental Anxiety? Have you ever been hospitalia Have you ever had a serious i Do you use tobacco? Do you use controlled substar Are you pregnant, trying to ge or taking oral contraceptive Please list all medications you	nces? t pregnant, nursing, es?	□ Yes □ No	□ As □ Ac □ Am □ Co □ Ce □ Ery □ Ott	rylic	petics
Name, Address and Phone N	lumber of your Primary Care Ph	hysician			
Check all that you currently hat AIDS/HIV Positive AIDS/HIV Positive AIZheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve* Artificial Joint* Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy	ave, or have had in the past. Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Cortisone Medicine Diabetes Drug Addiction Epilepsy or Seizures Excessive Bleeding Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Glaucoma Hearing Impaired	☐ Heart Attack ☐ Heart Murmu ☐ Heart Pace I ☐ Hemophilia ☐ Hepatitis A, I ☐ Herpes ☐ Hives or Ras ☐ Hypoglycem ☐ Irregular Hea ☐ Kidney Prob ☐ Leukemia ☐ Low Blood P ☐ Lung Diseas	ur* Maker* e/Disease B or C Pressure sh ia artbeat elems	□ Mitral Valve Prolapse* □ MRSA Disease □ Nervous Disorders □ Pain in Jaw Joints/TMJ □ Psychiatric Care □ Renal Disease/Problems □ Renal Dialysis □ Respiratory Problems □ Rheumatic Fever □ Shingles □ Sickle Cell Disease □ Sinus Trouble □ Spina Bifida □ Stomach/Intestinal Disease	Swelling of Limbs Thyroid/Parathyroid Disease Tonsillitis Tumors or Growths Ulcers Yellow Jaundice Notes:
	mation about my dental care			-	elow.
Name:	Name:			Name:	
☐ Prescription Required This authorization will be updated information released prior to that I will need to complete a start of the best of my knowledge.	ox next to the specific information uest Request/Confirm/Carated every 12 months. I have the hat date. If I want to grant permiseparate Release of Information ge, the questions on this form here.	ncel Appointments ne right to revoke thi nission to GVD to dis n form. ave been accurately	☐ Treatments authorization scuss any other years wered.	ent Plan	ocation will not cover esides myself, I understand
Patient/Parent	/Legal Guardian Signature			Date	



PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Print Name:				
Signature:				
Date:				
FOR OFFICE USE ONLY				
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:				
O Individual refused to sign				
O Communications barriers prohibited obtaining the acknowledgment				
O An emergency situation prevented us from obtaining acknowledgment				
Other (Please Specify)				